The definitions provided below have been gathered from various Regulations documents and other public use industry sources and for general reference use only.

~ A ~

**Accredited Standards Committee (ASC):** An organization that has been accredited by ANSI for the development of American National Standards.

**ACH:** See Automated Clearinghouse.

**ADA:** See American Dental Association.

**Administrative Code Sets:** Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as non-clinical or non-medical code sets. Compare to medical code sets.

**Administrative Services Only (ASO):** An arrangement whereby a self-insured entity contracts with a Third Party Administrator (TPA) to administer a health plan.

**Administrative Simplification (A/S):** Title II, Subtitle F, of HIPAA, which gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. This is also the name of Title II, Subtitle F, Part C of HIPAA.

**AHA:** See American Hospital Association.

**AHIMA:** See American Health Information Management Association.

**AMA:** See American Medical Association.

**American Dental Association (ADA):** A professional organization for dentists. The ADA maintains a hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT™) medical code set. The ADA and the Dental Content Committee (DeCC), which it hosts, have formal consultative roles under HIPAA.

**American Health Information Management Association (AHIMA):** An association of health information management professionals. AHIMA sponsors some HIPAA educational seminars.

**American Hospital Association (AHA):** A health care industry association that represents the concerns of institutional providers. The AHA hosts the NUBC, which has a formal consultative role under HIPAA.

**American Medical Association (AMA):** A professional organization for physicians. The AMA is the secretariat of the NUCC, which has a formal consultative role under HIPAA. The AMA also maintains the Current Procedural Terminology (CPT™) medical code set.

**American Medical Informatics Association (AMIA):** A professional organization that promotes the development and use of medical informatics for patient care, teaching, research, and health care administration.
AFEHCT: See Association for Electronic Health Care Transactions.

American National Standards (ANS): Standards developed and approved by organizations accredited by ANSI.

American National Standards Institute (ANSI): An organization that accredits various standards-setting committees, and monitors their compliance with the open rule-making process that they must follow to qualify for ANSI accreditation. HIPAA prescribes that the standards mandated under it be developed by ANSI-accredited bodies whenever practical.

American Society for Testing and Materials (ASTM): A standards group that has published general guidelines for the development of standards, including those for health care identifiers. ASTM Committee E31 on Healthcare Informatics develops standards on information used within healthcare.

AMIA: See the American Medical Informatics Association.

ANS: See American National Standards.

ANSI: See the American National Standards Institute. Also see Part II, 45 CFR 160.103.

A/S, A.S., or AS: See Administrative Simplification.

ASC: See Accredited Standards Committee.

ASO: See Administrative Services Only.

Association for Electronic Health Care Transactions (AFEHCT): An organization that promotes the use of EDI in the health care industry.

ASTM: See the American Society for Testing and Materials.


Availity® Health Information Network: The secure internet gateway developed by Availity, L.L.C. to connect health care providers to health care plans and payers.

Availity® Health Information Exchange: The interactive real-time and EDI batch products and services developed by Availity, L.L.C. to enable the exchange of health care administrative and clinical data among authorized health care entities.

~ B ~

BA: See Business Associate.

Blue Cross and Blue Shield Association (BCBSA): An association that represents the common interests of Blue Cross and Blue Shield health plans. The BCBSA serves as the administrator for the Health Care Code Maintenance Committee and also helps maintain the HCPCS Level II codes.

Business Associate (BA): A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity’s workforce. A business associate can also be a covered entity in its own right. Also see Part II, 45 CFR 160.103.

Business Relationships:
- The term agent is often used to describe a person or organization that assumes some of the responsibilities of another one. This term has been avoided in the final rules so that a
more HIPAA-specific meaning could be used for business associate. The term business partner (BP) was originally used for business associate.

- A Third Party Administrator (TPA) is a business associate that performs claims administration and related business functions for a self-insured entity.
- Under HIPAA, a health care clearinghouse is a business associate that translates data to or from a standard format in behalf of a covered entity.
- The HIPAA Security NPRM used the term Chain of Trust Agreement to describe the type of contract that would be needed to extend the responsibility to protect health care data across a series of sub-contractual relationships.
- While a business associate is an entity that performs certain business functions for you, a trading partner is an external entity, such as a customer, that you do business with. This relationship can be formalized via a trading partner agreement. It is quite possible to be a trading partner of an entity for some purposes, and a business associate of that entity for other purposes.

~ C ~

CE: See Covered Entity.

Centers for Disease Control and Prevention (CDC): An organization that maintains several code sets included in the HIPAA standards, including the ICD-9-CM codes.

Center for Healthcare Information Management (CHIM): A health information technology industry association.


Chain of Trust (COT): A term used in the HIPAA Security NPRM for a pattern of agreements that extend protection of health care data by requiring that each covered entity that shares health care data with another entity require that that entity provide protections comparable to those provided by the covered entity, and that that entity, in turn, require that any other entities with which it shares the data satisfy the same requirements.

Claim Adjustment Reason Codes: A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer’s payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.

Claim Attachment: Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

Claim Medicare Remark Codes: See Medicare Remittance Advice Remark Codes.

Claim Status Codes: A national administrative code set that identifies the status of health care claims. This code set is used in the X12 277 Claim Status Notification transaction, and is maintained by the Health Care Code Maintenance Committee.

Claim Status Category Codes: A national administrative code set that indicates the general category of the status of health care claims. This code set is used in the X12 277 Claim Status Notification transaction, and is maintained by the Health Care Code Maintenance Committee.
Clearinghouse: See Health Care Clearinghouse.

CLIA: Clinical Laboratory Improvement Amendments.

Clinical Code Sets: See Medical Code Sets.

COB: See Coordination of Benefits.

Code Set: Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. Also see Part II, 45 CFR 162.103.

Code Set Maintaining Organization: Under HIPAA, this is an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted. Also see Part II, 45 CFR 162.103.

Comment: Public commentary on the merits or appropriateness of proposed or potential regulations provided in response to an NPRM, an NOI, or other federal regulatory notice.

Compliance Date: Under HIPAA, this is the date by which a covered entity must comply with a standard, an implementation specification, or a modification. This is usually 24 months after the effective date of the associated final rule for most entities, but 36 months after the effective date for small health plans. For future changes in the standards, the compliance date would be at least 180 days after the effective date, but can be longer for small health plans and for complex changes. Also see Part II, 45 CFR 160.103.

Coordination of Benefits (COB): A process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

Covered Entity (CE): Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. Also see Part II, 45 CFR 160.103.

Covered Function: Functions that make an entity a health plan, a health care provider, or a health care clearinghouse. Also see Part II, 45 CFR 164.501.


Cross-over: See Coordination of Benefits.

Cross-walk: See Data Mapping.

Current Dental Terminology (CDT): A medical code set, maintained and copyrighted by the ADA, that has been selected for use in the HIPAA transactions.

Current Procedural Terminology (CPT): A medical code set, maintained and copyrighted by the AMA, that has been selected for use under HIPAA for non-institutional and non-dental professional transactions.

Data Condition: A description of the circumstances in which certain data is required. Also see Part II, 45 CFR 162.103.
**Data Content:** Under HIPAA, this is all the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Also see Part II, 45 CFR 162.103.

**Data Element:** Under HIPAA, this is the smallest named unit of information in a transaction. Also see Part II, 45 CFR 162.103.

**Data Interchange Standards Association (DISA):** A body that provides administrative services to X12 and several other standards-related groups.

**Data Mapping:** The process of matching one set of data elements or individual code values to their closest equivalents in another set of them. This is sometimes called a cross-walk.

**D-Codes:** A subset of the HCPCS Level II medical code set with a high-order value of “D” that has been used to identify certain dental procedures. The final HIPAA transactions and code sets rule states that these D-codes will be dropped from the HCPCS, and that CDT codes will be used to identify all dental procedures.

**DDE:** See Direct Data Entry.

**Designated Code Set:** A medical code set or an administrative code set that HHS has designated for use in one or more of the HIPAA standards.

**Designated Record Set:** See Part II, 45 CFR 164.501.

**Designated Standard:** A standard which HHS has designated for use under the authority provided by HIPAA.

**Designated Standard Maintenance Organization (DSMO):** See Part II, 45 CFR 162.103.

**DHHS:** See HHS.

**DICOM:** See Digital Imaging and Communications in Medicine.

**Digital Imaging and Communications in Medicine (DICOM):** A standard for communicating images, such as x-rays, in a digitized form. This standard could become part of the HIPAA claim attachments standards.

**Direct Data Entry (DDE):** Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan’s computer. Also see Part II, 45 CFR 162.103.

**DISA:** See the Data Interchange Standards Association.

**Disclosure:** Release or divulgence of information by an entity to persons or organizations outside of that entity. Also see Part II, 45 CFR 164.501.

**Disclosure History:** Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

**DME:** Durable Medical Equipment.

**DMERC:** See Medicare Durable Medical Equipment Regional Carrier.

**Draft Standard for Trial Use (DSTU):** An archaic term for any X12 standard that has been approved since the most recent release of X12 American National Standards. The current equivalent term is “X12 standard”.

**DHHS:** See HHS.
DRG: Diagnosis Related Group.

DSMO: See Designated Standard Maintenance Organization.

DSTU: See Draft Standard for Trial Use.

~ E ~

EC: See Electronic Commerce.

EDI: See Electronic Data Interchange.

EDIFACT: See United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport (UN/EDIFACT).

EDI Translator: A software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.

Effective Date: Under HIPAA, this is the date that a final rule is effective, which is usually 60 days after it is published in the Federal Register.

EFT: See Electronic Funds Transfer.

EHNAC: See the Electronic Healthcare Network Accreditation Commission.

EIN: Employer Identification Number.

Electronic Commerce (EC): The exchange of business information by electronic means.

Electronic Data Interchange (EDI): This usually means X12 and similar variable-length formats for the electronic exchange of structured data. It is sometimes used more broadly to mean any electronic exchange of formatted data.

Electronic Healthcare Network Accreditation Commission (EHNAC): An organization that tests transactions for consistency with the HIPAA requirements, and that accredits health care clearinghouses.

Electronic Media: See Part II, 45 CFR 162.103.

Electronic Media Claims (EMC): This term usually refers to a flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional 1500 NSF.

Electronic Remittance Advice (ERA): Any of several electronic formats for explaining the payments of health care claims.

EMC: See Electronic Media Claims.

EMR: Electronic Medical Record.
EOB: Explanation of Benefits.
EOMB: Explanation of Medicare Benefits, Explanation of Medicaid Benefits, or Explanation of Member Benefits.
EPSDT: Early & Periodic Screening, Diagnosis, and Treatment.
ERA: See Electronic Remittance Advice.

~ F ~

FFS: Fee-for-Service.
FI: See Medicare Part A Fiscal Intermediary.
Flat File: This term usually refers to a file that consists of a series of fixed-length records that include some sort of record type code.
Format: Under HIPAA, this is those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction. Also see Part II, 45 CFR 162.103.
FR or F.R.: Federal Register.

~ G ~

Group Health Plan: Under HIPAA this is an employee welfare benefit plan that provides for medical care and that either has 50 or more participants or is administered by another business entity. Also see Part II, 45 CFR 160.103.

~ H ~

HCFA Common Procedural Coding System (HCPCS):
A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. It has been selected for use in the HIPAA transactions.

- HCPCS Level I contains numeric CPT codes which are maintained by the AMA.
- HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These are maintained by CMS, the BCBSA, and the HIAA.
- HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These are usually called “local codes, and must have “W”, “X”, “Y”, or “Z” in the first position.
• HCPCS Procedure Modifier Codes can be used with all three levels, with the WA - ZY range used for locally assigned procedure modifiers.

**HCPCS:** See HCFA Common Procedural Coding System. Also see Part II, 45 CFR 162.103.

**Health and Human Services (HHS):** The federal government department that has overall responsibility for implementing HIPAA.

**Health Care:** See Part II, 45 CFR 160.103.

**Health Care Clearinghouse:** From Part II, 45 CFR 160.103. Health care clearinghouse means a public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health management information systems or community health information systems, and “value-added” networks and switches are health care clearinghouses for purposes of this subchapter if they perform these functions.):

1. Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
2. Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

**Health Care Code Maintenance Committee:** An organization administered by the BCBSA that is responsible for maintaining certain coding schemes used in the X12 transactions and elsewhere. These include the Claim Adjustment Reason Codes, the Claim Status Category Codes, and the Claim Status Codes.

**Health Care Component:** See Part II, 45 CFR 164.504.

**Healthcare Financial Management Association (HFMA):** An organization for the improvement of the financial management of healthcare-related organizations. The HFMA sponsors some HIPAA educational seminars.

**Health Care Financing Administration (HCFA):** The HHS agency responsible for Medicare and parts of Medicaid. HCFA has historically maintained the UB-92 institutional EMC format specifications, the professional 1500 EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. HCFA also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set. HCFA is now referred to as CMS – Centers for Medicare and Medicaid Services.

**Healthcare Information Management Systems Society (HIMSS):** A professional organization for healthcare information and management systems professionals.

**Health Care Operations:** See Part II, 45 CFR 164.501.

**Health Care Provider:** From Part II, 45 CFR 160.103. Health care provider means a provider of services as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u), a provider of medical or other health services as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

**Health Care Provider Taxonomy Committee:** An organization administered by the NUCC that is responsible for maintaining the Provider Taxonomy coding scheme used in the X12 transactions. The detailed code maintenance is done in coordination with X12N/TG2/WG15.
Health Insurance Association of America (HIAA): An industry association that represents the interests of commercial health care insurers. The HIAA participates in the maintenance of some code sets, including the HCPCS Level II codes.

Health Insurance Issuer (as defined in section 2791(b) of the PHS Act, 42 U.S.C. 300gg-91(b)(2), and used in the definition of health plan in this section) means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

Health Level Seven (HL7): An ANSI-accredited group that defines standards for the cross-platform exchange of information within a health care organization. HL7 is responsible for specifying the Level Seven OSI standards for the health industry. The X12 275 transaction will probably incorporate the HL7 CRU message to transmit claim attachments as part of a future HIPAA claim attachments standard. The HL7 Attachment SIG is responsible for the HL7 portion of this standard.

Health Maintenance Organization (HMO): From Part II, 45 CFR 160.103. Health maintenance organization (HMO) (as defined in section 2791 of the PHS Act, 42 U.S.C. 300gg–91(b)(3), and used in the definition of health plan in this section) means a Federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

Health Plan: From Part II, 45 CFR 160.103. Health plan means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg–91(a)(2)). Health plan includes, when applied to government funded programs, the components of the government agency administrating the program. Health plan includes the following, singly or in combination:

1. A group health plan, as defined in this section.
2. A health insurance issuer, as defined in this section.
3. An HMO, as defined in this section.
4. Part A or Part B of the Medicare program under title XVIII of the Act.
5. The Medicaid program under title XIX of the Act, 42 U.S.C. 1396 et seq.
6. An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).
7. An issuer of a long-term care policy, excluding a nursing home fixed indemnity policy.
8. An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
11. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in 10 U.S.C. 1072(4).
(12) The Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).
(14) An approved State child health plan under title XXI of the Act, providing benefits that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397 et seq.
(16) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg–91(a)(2)).

**Health Plan ID:** See National Payer ID.

**HEDIC:** The Healthcare EDI Coalition.

**HEDIS:** Health Employer Data and Information Set.

**HFMA:** See the Healthcare Financial Management Association.

**HHA:** Home Health Agency.

**HHS:** See Health and Human Services. Also see Part II, 45 CFR 160.103.

**HIAA:** See the Health Insurance Association of America.

**HIBCC:** See the Health Industry Business Communications Council.

**HIMSS:** See the Healthcare Information Management Systems Society.

**HIPAA:** See the Health Insurance Portability and Accountability Act of 1996.

**HIPAA Data Dictionary or HIPAA DD:** A data dictionary that defines and cross-references the contents of all X12 transactions included in the HIPAA mandate. It is maintained by X12N/TG3.

**HISB:** See the Health Informatics Standards Board.

**HL7:** See Health Level Seven.

**HMO:** See Health Maintenance Organization.

**HPAG:** The HIPAA Policy Advisory Group, a BCBSA subgroup.

**HPSA:** Health Professional Shortage Area.

**Hybrid Entity:** A covered entity whose covered functions are not its primary functions. Also see Part II, 45 CFR 164.504.

~ I ~

**IAIABC:** See the International Association of Industrial Accident Boards and Commissions.

**ICD & ICD-n-CM & ICD-n-PCS:** International Classification of Diseases, with "n" = “9” for
Revision 9 or "10" for Revision 10, with “CM” = “Clinical Modification”, and with “PCS” = “Procedure Coding System”.

ICF: Intermediate Care Facility.

IDN: Integrated Delivery Network.

IIHI: See Individually Identifiable Health Information.

IG: See Implementation Guide.

IHC: Internet Healthcare Coalition.

Implementation Guide (IG): A document explaining the proper use of a standard for a specific business purpose. The X12N HIPAA IGs are the primary reference documents used by those implementing the associated transactions, and are incorporated into the HIPAA regulations by reference.

Implementation Specification: Under HIPAA, this is the specific instructions for implementing a standard. Also see Part II, 45 CFR 160.103. See also Implementation Guide.

Individually Identifiable Health Information (IIHI):
See Part II, 45 CFR 164.501.

International Classification of Diseases (ICD): A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set was to classify causes of death. A US extension, maintained by the NCHS within the CDC, identifies morbidity factors, or diagnoses. The ICD-9-CM codes have been selected for use in the HIPAA transactions.

International Organization for Standardization (ISO): An organization that coordinates the development and adoption of numerous international standards. "ISO" is not an acronym, but the Greek word for "equal".


ISO: See the International Organization for Standardization.

~ J ~

JCAHO: See the Joint Commission on Accreditation of Healthcare Organizations.

J-Codes: A subset of the HCPCS Level II code set with a high-order value of “J” that has been used to identify certain drugs and other items. The final HIPAA transactions and code sets rule states that these J-codes will be dropped from the HCPCS, and that NDC codes will be used to identify the associated pharmaceuticals and supplies.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): An organization that accredits healthcare organizations. In the future, the JCAHO may play a role in certifying these organizations’ compliance with the HIPAA A/S requirements.
Local Code(s): A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also applies to state-assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.

Logical Observation Identifiers, Names and Codes (LOINC™): A set of universal names and ID codes that identify laboratory and clinical observations. These codes, which are maintained by the Regenstrief Institute, are expected to be used in the HIPAA claim attachments standard.

LOINC™: See Logical Observation Identifiers, Names and Codes.

Loop: A repeating structure or process.

Maximum Defined Data Set: Under HIPAA, this is all of the required data elements for a particular standard based on a specific implementation specification. An entity creating a transaction is free to include whatever data any receiver might want or need. The recipient is free to ignore any portion of the data that is not needed to conduct their part of the associated business transaction, unless the inessential data is needed for coordination of benefits. Also see Part II, 45 CFR 162.103.

MCO: Managed Care Organization.


Medicaid Fiscal Agent (FA): The organization responsible for administering claims for a state Medicaid program.

Medicaid State Agency: The state agency responsible for overseeing the state’s Medicaid program.

Medical Code Sets: Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations. Compare to administrative code sets.

Medical Records Institute (MRI): An organization that promotes the development and acceptance of electronic health care record systems.

Medicare Contractor: A Medicare Part A Fiscal Intermediary, a Medicare Part B Carrier, or a Medicare Durable Medical Equipment Regional Carrier (DMERC).

Medicare Durable Medical Equipment Regional Carrier (DMERC): A Medicare contractor responsible for administering Durable Medical Equipment (DME) benefits for a region.
Medicare Part A Fiscal Intermediary (FI): A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.

Medicare Part B Carrier: A Medicare contractor that administers the Medicare Part B (Professional) benefits for a given region.

Medicare Remittance Advice Remark Codes: A national administrative code set for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice transaction, and is maintained by the HCFA.

Memorandum of Understanding (MOU): A document providing a general description of the responsibilities that are to be assumed by two or more parties in their pursuit of some goal(s). More specific information may be provided in an associated SOW.

Minimum Scope of Disclosure: The principle that, to the extent practical, individually identifiable health information should only be disclosed to the extent needed to support the purpose of the disclosure.

Modify or Modification: Under HIPAA, this is a change adopted by the Secretary, through regulation, to a standard or an implementation specification. Also see Part II, 45 CFR 160.103.

MOU: See Memorandum of Understanding.

MR: Medical Review.

MSP: Medicare Secondary Payer.

~ N ~

NAHDO: See the National Association of Health Data Organizations.

NAIC: See the National Association of Insurance Commissioners.

National Association of Health Data Organizations (NAHDO): A group that promotes the development and improvement of state and national health information systems.

National Association of Insurance Commissioners (NAIC): An association of the insurance commissioners of the states and territories.

National Center for Health Statistics (NCHS): A federal organization within the CDC that collects, analyzes, and distributes health care statistics. The NCHS maintains the ICD-n-CM codes.

National Committee for Quality Assurance (NCQA): An organization that accredits managed care plans, or Health Maintenance Organizations (HMOs). In the future, the NCQA may play a role in certifying these organizations’ compliance with the HIPAA A/S requirements. The NCQA also maintains the Health Employer Data and Information Set (HEDIS).

National Committee on Vital and Health Statistics (NCVHS): A Federal advisory body within HHS that advises the Secretary regarding potential changes to the HIPAA standards.

National Council for Prescription Drug Programs (NCPDP): An ANSI-accredited group that
maintains a number of standard formats for use by the retail pharmacy industry, some of which are included in the HIPAA mandates.

**National Drug Code (NDC):** A medical code set that identifies prescription drugs and some over the counter products, and that has been selected for use in the HIPAA transactions.

**National Employer ID:** A system for uniquely identifying all sponsors of health care benefits.

**National Health Information Infrastructure (NHII):**
This is a healthcare-specific lane on the Information Superhighway, as described in the National Information Infrastructure (NII) initiative. Conceptually, this includes the HIPAA A/S initiatives.

**National Patient ID:** A system for uniquely identifying all recipients of health care services. This is sometimes referred to as the National Individual Identifier (NII), or as the Healthcare ID.

**National Payer ID:** A system for uniquely identifying all organizations that pay for health care services. Also known as Health Plan ID, or Plan ID.

**National Provider ID (NPI):** A system for uniquely identifying all providers of health care services, supplies, and equipment.

**National Provider File (NPF):** The database envisioned for use in maintaining a national provider registry.

**National Provider Registry:** The organization envisioned for assigning National Provider IDs.

**National Provider System (NPS):** The administrative system envisioned for supporting a national provider registry.

**National Standard Format (NSF):** Generically, this applies to any nationally standardized data format, but it is often used in a more limited way to designate the Professional 1500 EMC NSF, a 320-byte flat file record format used to submit professional claims.

**National Uniform Billing Committee (NUBC):** An organization, chaired and hosted by the American Hospital Association, that maintains the UB-92 hardcopy institutional billing form and the data element specifications for both the hardcopy form and the 192-byte UB-92 flat file EMC format. The NUBC has a formal consultative role under HIPAA for all transactions affecting institutional health care services.

**National Uniform Claim Committee (NUCC):** An organization, chaired and hosted by the American Medical Association, that maintains the CMS-1500 claim form and a set of data element specifications for professional claims submission via the CMS-1500 claim form, the Professional EMC NSF, and the X12 837. The NUCC also maintains the Provider Taxonomy Codes and has a formal consultative role under HIPAA for all transactions affecting non-dental non-institutional professional health care services.

**NCHS:** See the National Center for Health Statistics.

**NCPDP:** See the National Council for Prescription Drug Programs.

**NCPDP Batch Standard:** An NCPDP standard designed for use by low-volume dispensers of pharmaceuticals, such as nursing homes. Use of Version 1.0 of this standard has been mandated under HIPAA.

**NCPDP Telecommunication Standard:** An NCPDP standard designed for use by high-volume
dispensers of pharmaceuticals, such as retail pharmacies. Use of Version 5.1 of this standard has been mandated under HIPAA.

**NCQA:** See the National Committee for Quality Assurance.

**NCVHS:** See the National Committee on Vital and Health Statistics.

**NDC:** See National Drug Code.

**NHII:** See National Health Information Infrastructure.

**Non-Clinical or Non-Medical Code Sets:** See Administrative Code Sets.

**Notice of Intent (NOI):** A document that describes a subject area for which the Federal Government is considering developing regulations. It may describe the presumably relevant considerations and invite comments from interested parties. These comments can then be used in developing an NPRM or a final regulation.

**Notice of Proposed Rulemaking (NPRM):** A document that describes and explains regulations that the Federal Government proposes to adopt at some future date, and invites interested parties to submit comments related to them. These comments can then be used in developing a final regulation.

**NPF:** See National Provider File.

**NPI:** See National Provider ID.

**NPRM:** See Notice of Proposed Rulemaking.

**NPS:** See National Provider System.

**NSF:** See National Standard Format.

**NUBC:** See the National Uniform Billing Committee.

**NUBC EDI TAG:** The NUBC EDI Technical Advisory Group, which coordinates issues affecting both the NUBC and the X12 standards.

**NUCC:** See the National Uniform Claim Committee.

~ O ~

**OCR:** See the Office for Civil Rights.

**Office for Civil Rights:** The HHS entity responsible for enforcing the HIPAA privacy rules.

**Office of Management & Budget (OMB):** A Federal Government agency that has a major role in reviewing proposed Federal regulations.

**OIG:** Office of the Inspector General.

**OMB:** See the Office of Management & Budget.
Open System Interconnection (OSI): A multi-layer ISO data communications standard. Level Seven of this standard is industry-specific, and HL7 is responsible for specifying the level seven OSI standards for the health industry.


Payer: In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan, or an HMO.


Provider Taxonomy Codes: An administrative code set for identifying the provider type and area of specialization for all health care providers. A given provider can have several Provider Taxonomy Codes. This code set is used in the X12 278 Referral Certification and Authorization and the X12 837 Claim transactions, and is maintained by the NUCC.

RA: Remittance Advice.

Regenstrief Institute: A research foundation for improving health care by optimizing the capture, analysis, content, and delivery of health care information. Regenstrief maintains the LOINC coding system that is being considered for use as part of the HIPAA claim attachments standard.

SDO: Standards Development Organization.

Segment: Under HIPAA, this is a group of related data elements in a transaction. Also see Part II, 45 CFR 162.103.

Small Health Plan: Under HIPAA, this is a health plan with annual receipts of $5 million or less. Also see Part II, 45 CFR 160.103.

SNF: Skilled Nursing Facility.

SNOMED: Systematized Nomenclature of Medicine.


Sponsor: See Plan Sponsor.

SOW: See Statement of Work.
SSN: Social Security Number.

SSO: See Standard-Setting Organization.

Standard: See Part II, 45 CFR 160.103.


Standard Transaction: Under HIPAA, this is a transaction that complies with the applicable HIPAA standard. Also see Part II, 45 CFR 162.103.


State Law: A constitution, statute, regulation, rule, common law, or any other State action having the force and effect of law. Also see Part II, 45 CFR 160.202.

State Uniform Billing Committee (SUBC): A state-specific affiliate of the NUBC.

Statement of Work (SOW): A document describing the specific tasks and methodologies that will be followed to satisfy the requirements of an associated contract or MOU.

Strategic National Implementation Process (SNIP): A WEDI program for helping the health care industry identify and resolve HIPAA implementation issues.

Summary Health Information: See Part II, 45 CFR 164.504.

SWG: Subworkgroup.

Syntax: The rules and conventions that one needs to know or follow in order to validly record information, or interpret previously recorded information, for a specific purpose. Thus, a syntax is a grammar. Such rules and conventions may be either explicit or implicit. In X12 transactions, the data-element separators, the sub-element separators, the segment terminators, the segment identifiers, the loops, the loop identifiers (when present), the repetition factors, etc., are all aspects of the X12 syntax. When explicit, such syntactical elements tend to be the structural, or format-related, data elements that are not required when a direct data entry architecture is used. Ultimately, though, there is not a perfectly clear division between the syntactical elements and the business data content.


Third Party Administrator (TPA): An entity that processes health care claims and performs related business functions for a health plan.

TPA: See Third Party Administrator or Trading Partner Agreement.


Transaction: Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care. Also see Part II, 45 CFR 160.103.

Transaction Change Request System: A system established under HIPAA for accepting and tracking
change requests for any of the HIPAA mandated transactions standards via a single web site. See www.hipaa-dsmo.org.

**Translator:** See EDI Translator.

~ U ~

**UB:** Uniform Bill, as in UB-82 or UB-92.

**UB-92:** A uniform institutional claim form developed by the NUBC that has been in general use since 1993.

**UCF:** Uniform Claim Form, as in UCF-1500.

**UN/CEFACT:** See the United Nations Centre for Facilitation of Procedures and Practices for Administration, Commerce, and Transport.

**UN/EDIFACT:** See the United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport.

**Uniform Claim Task Force (UCTF):** An organization that developed the initial HCFA-1500 Professional Claim Form. The maintenance responsibilities were later assumed by the NUCC.

**United Nations Centre for Facilitation of Procedures and Practices for Administration, Commerce, and Transport (UN/CEFACT):** An international organization dedicated to the elimination or simplification of procedural barriers to international commerce.

**United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport (UN/EDIFACT):** An international EDI format. Interactive X12 transactions use the EDIFACT message syntax.

**UNSM:** United Nations Standard Messages.

**Unstructured Data:** See Data-Related Concepts.

**UPIN:** Unique Physician Identification Number.

**UR:** Utilization Review.

**USC or U.S.C:** United States Code.

~ V ~

**Value-Added Network (VAN):** A vendor of EDI data communications and translation services.

**VAN:** See Value-Added Network.

**Virtual Private Network (VPN):** A technical strategy for creating secure connections, or tunnels, over the internet.

**VPN:** See Virtual Private Network.
Washington Publishing Company (WPC): The company that publishes the X12N HIPAA Implementation guides and the X12N HIPAA Data Dictionary, that also developed the X12 Data Dictionary, and that hosts the EHNAC STFCS testing program.

WEDI: See the Workgroup for Electronic Data Interchange.

WG: Work Group.

WHO: See the World Health Organization.

Workforce: Under HIPAA, this means employees, volunteers, trainees, and other persons under the direct control of a covered entity, whether or not they are paid by the covered entity. Also see Part II, 45 CFR 160.103.

Workgroup for Electronic Data Interchange (WEDI): A health care industry group that lobbied for HIPAA A/S, and that has a formal consultative role under the HIPAA legislation. WEDI also sponsors SNIP.

World Health Organization (WHO): An organization that maintains the International Classification of Diseases (ICD) medical code set.

WPC: See the Washington Publishing Company.

X12: An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.

X12 148: The X12 First Report of Injury, Illness, or Incident transaction. This standard could eventually be included in the HIPAA mandate.

X12 270: The X12 Health Care Eligibility & Benefit Inquiry transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 271: The X12 Health Care Eligibility & Benefit Response transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 274: The X12 Provider Information transaction.

X12 275: The X12 Patient Information transaction. This transaction is expected to be part of the HIPAA claim attachments standard.

X12 276: The X12 Health Care Claims Status Inquiry transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 277: The X12 Health Care Claim Status Response transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates. This transaction is also expected to be part of the HIPAA claim attachments standard.
X12 278: The X12 Referral Certification and Authorization transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 820: The X12 Payment Order & Remittance Advice transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 834: The X12 Benefit Enrollment & Maintenance transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 835: The X12 Health Care Claim Payment & Remittance Advice transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 837: The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims. Version 4010 of this transaction has been included in the HIPAA mandates.

X12 997: The X12 Functional Acknowledgement transaction.

X12F: A subcommittee of X12 that defines EDI standards for the financial industry. This group maintains the X12 811 [generic] Invoice and the X12 820 [generic] Payment & Remittance Advice transactions, although X12N maintains the associated HIPAA Implementation guides.

X12 IHCEBI & IHCEBR: The X12 Interactive Healthcare Eligibility & Benefits Inquiry (IHCEBI) and Response (IHCEBR) transactions. These are being combined and converted to UN/EDIFACT Version 5 syntax.

X12 IHCLME: The X12 Interactive Healthcare Claim transaction.

X12J: A subcommittee of X12 that reviews X12 work products for compliance with the X12 design rules.

X12N: A subcommittee of X12 that defines EDI standards for the insurance industry, including health care insurance.

X12N/SPTG4: The HIPAA Liaison Special Task Group of the Insurance Subcommittee (N) of X12. This group’s responsibilities have been assumed by X12N/TG3/WG3.

X12N/TG1: The Property & Casualty Task Group (TG1) of the Insurance Subcommittee (N) of X12.

X12N/TG2: The Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12.

X12N/TG2/WG1: The Health Care Eligibility Work Group (WG1) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 270 Health Care Eligibility & Benefit Inquiry and the X12 271 Health Care Eligibility & Benefit Response transactions, and is also responsible for maintaining the IHCEBI and IHCEBR transactions.

X12N/TG2/WG2: The Health Care Claims Work Group (WG2) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 837 Health Care Claim or Encounter transaction.

X12N/TG2/WG3: The Health Care Claim Payments Work Group (WG3) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 835 Health Care Claim Payment & Remittance Advice transaction.

X12N/TG2/WG4: The Health Care Enrollments Work Group (WG4) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 834 Benefit Enrollment &
Maintenance transaction.

**X12N/TG2/WG5:** The Health Care Claims Status Work Group (WG5) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 276 Health Care Claims Status Inquiry and the X12 277 Health Care Claim Status Response transactions.

**X12N/TG2/WG9:** The Health Care Patient Information Work Group (WG9) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 275 Patient Information transaction.

**X12N/TG2/WG10:** The Health Care Services Review Work Group (WG10) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 278 Referral Certification and Authorization transaction.

**X12N/TG2/WG12:** The Interactive Health Care Claims Work Group (WG12) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the IHCLME Interactive Claims transaction.

**X12N/TG2/WG15:** The Health Care Provider Information Work Group (WG15) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of X12. This group maintains the X12 274 Provider Information transaction.

**X12N/TG3:** The Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of X12. TG3 maintains the X12N Business and Data Models and the HIPAA Data Dictionary.

**X12N/TG3/WG2:** The Healthcare Business & Information Modeling Work Group (WG2) of the Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of X12.

**X12N/TG3/WG3:** The HIPAA Implementation Coordination Work Group (WG3) of the Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of X12. This was formerly X12N/TG2/WG19 and X12N/SPTG4.

**X12N/TG4:** The Implementation Guide Task Group (TG4) of the Insurance Subcommittee (N) of X12. This group supports the development and maintenance of X12 Implementation Guides, including the HIPAA X12 IGs.

**X12N/TG8:** The Architecture Task Group (TG8) of the Insurance Subcommittee (N) of X12.

**X12/PRB:** The X12 Procedures Review Board.

**X12 Standard:** The term currently used for any X12 standard that has been approved since the most recent release of X12 American National Standards. Since a full set of X12 American National Standards is only released about once every five years, it is the X12 standards that are most likely to be in active use. These standards were previously called Draft Standards for Trial Use.

**XML:** Extensible Markup Language.